DME Task Force Meeting
Medical Services Division
DME Related Questions
OCTOBER 11, 2016

Location: North Dakota State Capitol in Bismarck
Judicial Wing 2nd Floor – AV Room 210-212

Time: 1:00 p.m. to 3:00 p.m.

Medical Services General Statement: The main purpose of the DME Task Force Meeting is to be a working group to discuss current policy and to bring recommendations to the table for Medical Services to take into consideration. It is not meant to discuss individually denied cases. The Department's decisions are based on 42 CFR 440.230(d) and the North Dakota Administrative Code 75-02-02-08, which allows the Department to place appropriate limits on services based on such criteria as medical necessity or utilization control procedures.

Attendance:

Tammy Holm - Medical Services
Sue Burns – Medical Services
Jennifer Sands – Medical Services
Nikki Lyons – Medical Services
David Holmar – Bioventus
Cathy Dyke – Sanford
Brady Ness – Sanford
Darla Hanson – Unity Medical Center
Jes Berg – Unity Medical Center
Center Tara Kahl – Hanger Clinic
Linda Steeple – CPAP Store
Brenda Schultz – Altru
Barb Stockert – Sanford HCA
Brandy Burg – MedQuest
Tammy Zachmeier – Medical Services
Sara Regner – Medical Services
Doug Boknecht – Medical Services
Bruce Mettin – Trinity
Liz Rick – Sanford
Doug Schauer – Sanford
Lisa McCarthy – Bioventus
Mary Jo Henne – Sanford
Nadine Schanilec – Unity Medical
Kevin Holzer- Great Plains Bismarck
Pat Greenfield – Med Quest
Gail Urbance – Great Plains Dickinson
Nancy Froslie - Sanford HCA
Rodney S Askay – West River

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1. NDMA has been very particular that a patient must see their physician within 60 days of the prescription date. When a patient is receiving on-going PT/OT the therapist will recommend the patient get some sort of equipment, and the physician signs off on this recommendation.

   Is it really necessary for the patient to go back and see the physician if they haven't seen them within 60 days?

   If the doctor signs off on that therapy note, will that signed date count as the 60 days?

   North Dakota Medicaid Response:

   NDMA understands that in some incidences this may be acceptable, but due to new Medicare Face to Face requirements for many DME items the Department will continue to require the physician note. If the member was seen July 1st by their physician and on August 1st PT sees the member AFO is getting to small and they contact the physician stating this and the physician orders a new on it would be acceptable for the physician to add an addendum to the July 1st note to support the need.

2. Our patients often ask us how long it will take to have their product authorized by your Department. Considering we have all of the documentation from the physician, what is the acceptable time frame we should be telling them?

   North Dakota Medicaid Response:

   The new system has created a learning curve both for providers and the Department plus an increase in DME service auth. requests. The Department continues to ask for 30 days.

   What is the expectation for turn-around? Most of us have SA requests still out from months ago and recent ones are taking less than 10 days. Can a process to fix these outdated requests be put into place so we can service our clients?

   North Dakota Medicaid Response: Service authorization requests are completed thru the second week of September. Please email the SA numbers that is still showing pended prior to September for the Department to look into this.

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3. Considering all necessary documentation for a SA on Cranial Helmets has been submitted to you, is there any way to speed up the process?

   The recommended fitting time of these helmets is between 4-8 months of age when the majority of head growth is occurring. In order to achieve maximum results the helmets need to be placed on the head during this time so the growth can be captured and the head shape can be corrected within the helmet. In some situations these approvals are taking 30-45 days.

   North Dakota Medicaid Response:

   This issue was presented to the Department this last January for consideration. Since the new system has the option to pull up SAs by a HCPC (S1040) it would be possible for them to be reviewed on weekly bases.

   One issue that the Department noticed was the failure to provide the coverage cranial measurements and tummy time documentation which resulted in technical denials. To help eliminate this issue the Certificate of Medical Necessity was created an effective Feb. 15, 2016, the Certificate of Medical Necessity/Cranial Remolding Orthosis (SFN 580) was initiated. To help prevent delays please make sure that ALL areas are completed, signed and dated by the physician or the service authorization will be denied as incomplete as unable to process the request.

   The Department allows 7 days for providers to submit the supporting documents to be linked to the service auth. after which the request will be denied with a denial code 90 – info. not received.

   The Department has noticed that providers have been submitting service authorizations requests as medical instead of DME. When this is done it does not appear DME staff to review but goes to the medical area. If it goes the medical area it is voided as unable to process the request and the provider will need to resubmit a new SA along with a required supporting documents.

   Further Discussion: The Authorizations that providers are saying that are not processed as of today's date are probably submitted by the provider as a medical service authorization which then goes to the medical staff instead of the DME staff. If a service authorization is voided there is no notification sent to the providers.

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4. Are providers ever going to be able to view the reason a service authorization has denied? The option is available on the MMIS website, but no information is populated. Currently, we have to place a call to the NDMA Call Center and wait for the information. Sometimes they have to send a message to the ND staff to give us a call back, which can take up to a couple of weeks or so before anyone gets back to us.

   Additionally, will MMIS be updated to show what the reasons are for the request being denied? We were receiving letters stating the requests are denied, with no explanation, but were recently informed the denial reason would be added to these letters; however, these letters are not received in a timely manner, delaying the SA requests processing.

   North Dakota Medicaid Response:

   ND Medicaid is currently working on a resolution to add to all service authorization letters a reason for denial. It will take significant time for this enhancement on the ND Medicaid letters. Hopefully by end of 2017, this will be complete. Providers will still need to continue to contact the call center when questioning a reason for denial on their service authorization.

   As of 10/03/2016, the call center has been moved back to North Dakota. A twelve week training course took place to ensure the agents will able to answer any service authorizations, claims or benefit related questions. Continued education and training will be provided as we move forward.

   Further Discussion: If a provider receives a denial can the provider appeal? No, the provider cannot appeal a decision. The member can only request an appeal and the provider needs to submit a new service authorization with documentation for reconsideration, along with all required supporting docs.

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5. Recently we were submitting a service authorization for two items. We found out by communicating with Tammy that there was no longer a specified dollar amount and that the Fee Schedule should be referenced. We appreciate this change, but couldn't this information be communicated to all providers in a bulletin so that everyone is made aware of things like this?

   North Dakota Medicaid Response:

   Due to recent updates to the new system providers will no longer be required to submit a service authorization for all equipment or supplies at or above $750 or estimated annual cumulative supplies of $750 or more per year. Please reference the fee schedule to see if the hcpc requires a service authorization.

   The Department reminds Providers to make sure that they are requesting the appropriate number of units and appropriate modifiers on the service authorization and/or claim.

   Further Discussion: Exception to this rule is a new wheel chair. Please check the DME and Provider's Update web pages as updates are posted as needed.

6. We are often asked by your department to submit the original RX for an item. Can you please clarify what this means? We have clients who have used products for many years with no changes to their order. We are unsure if you want the very initial RX, or will you accept the annual RX that we are required by state law to get?

   North Dakota Medicaid Response:

   The DME manual states that a prescription for medical supplies used on a continuous basis must be renewed by a physician at least every 12 months and must specify the monthly quantity needed.

   The member is seen annually for renewal of the prescription. The physician will conduct an evaluation and based on this information will issue a new prescription (per the Departments prescription requirements) for the next 12 months**.**

   The physician note needs to have supporting documentation to support the continued medical necessity of the item being requested. Listing the item on the

medication list or mentioning in the physician note that member is taking, using or doing is not adequate.

For example;

1. Member is receiving Ensure via a peg tube or orally.
2. Member currently self cathing 4 times daily.
3. Member wears briefs.

If the item(s) ordered require a service authorization, all the normal requirements for prior approval must be met, and the Department must receive the service authorization request no later than 90 days from the date of the service or it will be denied as past timely filing and the provider will be liable.

Further Discussion: Written statements of medical necessity are needed. Documentation is needed along with an updated prescription. Provider needs to keep original prescription for seven years but need only to submit the annual or latest prescription and documentation to show medical necessity.

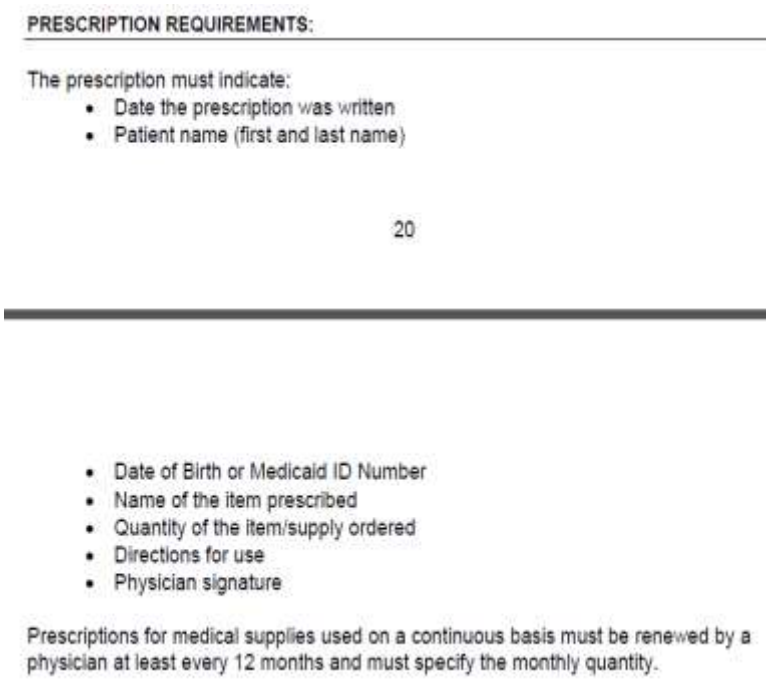
7. The provider manual explains what elements are needed for a dispensing order but it does not specify anywhere if that order can be verbal. Considering all other primary payers accept verbal orders, how would you like us to handle?

   Does ND Medical Assistance accept verbal dispensing orders? If so, how should they be documented?

   North Dakota Medicaid Response:

   The Department only requires a complete original prescription for DME items. Since a dispensing order/verbal dispensing order is a Medicare requirement, it would be best to address this question with them for appropriate guidance. If a provider needs clarification in a prescription they will need to contact the physician using their business practice method.

   Listed below is the current DME prescription requirements listed on page 20 of the current DME manuals.



PRESCRIPTION REQUIREMENTS:

The prescription must indicate:

- Date the prescription was written
- Patient name (first and last name)

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- Date of Birth or Medicaid ID Number
- Name of the item prescribed
- Quantity of the item/supply ordered
- Directions for use
- Physician signature

Prescriptions for medical supplies used on a continuous basis must be renewed by a physician at least every 12 months and must specify the monthly quantity.

Further Discussion:

- Clarification orders are fine to use but verbal orders still need the physician's signature. Direction of usage and some type of instruction has to be included. Verbal orders obtained for items not requiring SA are acceptable for dispensing, but need to be signed by billing, along with all other elements of the prescription requirements.
- Hearing aid batteries do you require referral or prescription? No authorization is required.

8. A SA is submitted, we get proof that the fax went through. NDMA states they did not get the documentation, they require us to submit a whole new SA which can then get timely. Is it possible to re-submit only the documentation with our confirmation that the fax was sent and went through?

North Dakota Medicaid Response:

In June the Department's ITD department looked into to this issue which was felt alleviated this issue. This is not believed to be an issue with the MMIS system. This is an issue of the Department not receiving the faxed items. It is problematic as tracking faxes is not easy process.

Providers can use either the fax number on the SFN 177 cover sheet 701-328-1544 or the old DME fax number 701-328-0370.

The NDMA's development team is working on MMIS to allow for attachments to be added to the electronic submission when the SA is submitted. Currently, NDMA's focus is on achieving certification, but please be assured that this issue is at the top of the list for correction.

The Department apologizes for the extra work this issue caused.

Further Discussion: The Department cannot change a SA once denied. Sanford is having problems getting faxes through. Is there a time line when providers can attach documents themselves. The Department is working on this issue of allowing providers to attach documents directly into the system and hopefully early 2017 this will be possible.

9. We've had one Service Authorization denied because we didn't enter in the "Notes" section of the recipient's insurance, ex: NDMA was primary or secondary. On the old forms there was a box to fill in the recipient's primary and secondary insurance. Could the MMIS be updated so this information could be added on the portal website?

North Dakota Medicaid Response:

Please reference the MMIS Service Authorization Provider Entry Instruction Handout section 10. Please see the highlighted section below. This information is utilized by ND Medicaid to determine if Medicaid is primary to help determine when it is more cost efficient to rent or purchase for the Department.

The complete MMIS Service Authorization Provider Entry Instruction Handout can be found at http://www.nd.gov/dhs/services/medicalserv/medicaid/provider-durable.html

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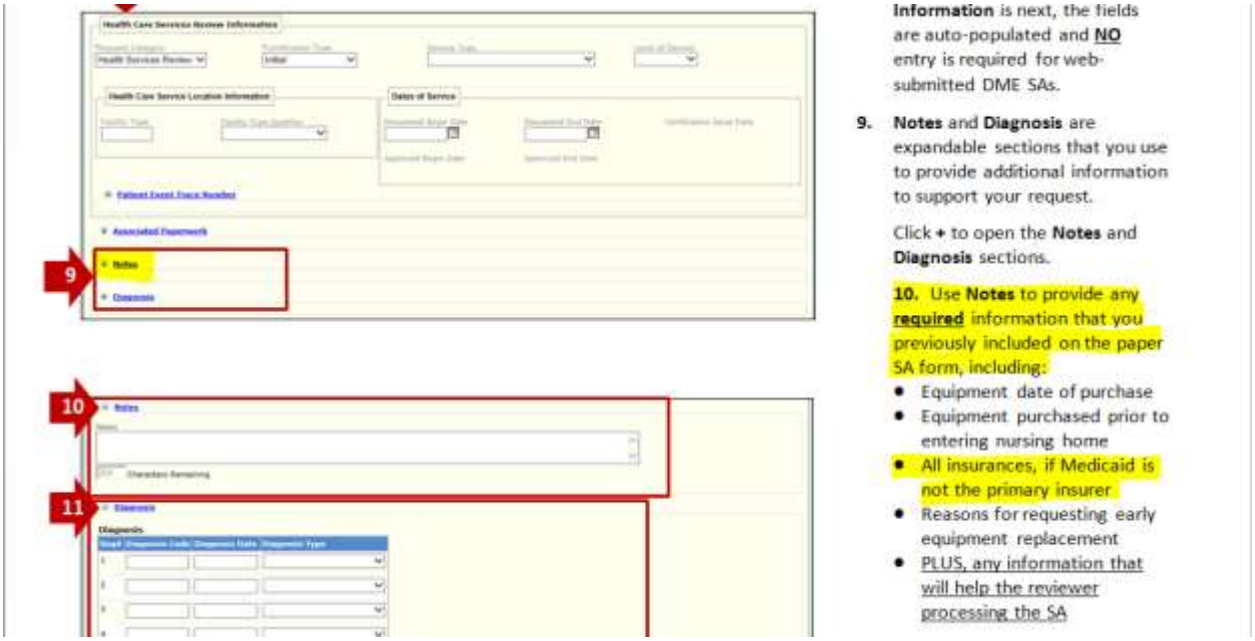

10. When will the DME manual be updated? Instructions in the manual vary and we are being told different things in different places.

    North Dakota Medicaid Response:

    The DME Manual revision has begun.

    Please email Tammy Holm at tamholm@nd.gov examples of the "instructions that vary" in the DME manual so it can be reviewed.

    We would like to receive complete written instructions on all processes such as submitting claims, refunding, voiding, and submitting service auth's. This would be extremely helpful especially when we are training new staff. We all need something to reference.

    North Dakota Medicaid Response:

    The Claims department has responded to request for instruction on submitting claims, refunds and voiding. Please see their response in the DME Task Force Meeting Claims Questions handout.

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The DME department's service authorization instructions are available at the link below.

MMIS Service Authorization Provider Entry Instruction Handout can be found at http://www.nd.gov/dhs/services/medicalserv/medicaid/provider-durable.html

11. An example of the confusion in the manual is it will state one thing in one area, and in another the information will be contradictory. See below example with a breast pump:

    Breast Pump- The manual shows in the bold of each item whether prior authorization is required. Under Breast Pump it shows prior authorization required but under the first paragraph it says no prior authorization required.

    (See attached copy of book)

    BREAST PUMP
    Prior Authorization Required.
    Effective 1/1/2012
    Revised 7-16-2013
    Reviewed 6-24-14
    E0603NU (ELECTRIC AC/DC, ANY TYPE);
    E0602NU (MANUAL, ANY TYPE);
    E0604RR (HOSPITAL GRADE ELECTRIC AC/DC, ANY TYPE):

    Manual (E0602NU) and Electric (E0603NU) breast pumps should be used to promote lactation and to provide lactation support when natural feeding is not possible. These items are available for purchase only and do not require prior authorization.

    Can these discrepancies be clarified?

North Dakota Medicaid Response:

7-16-2013 the DME Breast Pump policy was revised to help aid Medicaid mother's to receive needed pumps in a timely manner.

The Manual **(E0602NU)** and Electric **(E0603NU)** breast pumps are available for purchase only and do not require prior authorization.

The yellow highlighted verbiage below will be added to the new manual.

If rental of hospital grade electric breast pump is needed beyond 1 month a service authorization is required with documentation to supported continued need.

Medicaid Utilization Review staff will review the records to determine:

- If the hospital grade electric breast pump is still being utilized by the mother.
- If lactation cannot be initiated in the normal fashion or with a standard electric breast pump due to one of the conditions listed above.
- How much longer the breast pump is expected to be medically necessary?

Thank you for bring this to the Department's attention.

12. Would it be possible to stop submitting service authorizations on secondary claims, especially rentals? The paperwork and time that is spent on these is costing providers and the State of ND a terrific amount of time and money.

North Dakota Medicaid Response:

The Department is currently working with the development team on not requiring a service authorization on Medicare crossovers. Providers will be updated if and when this becomes possible.

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13. At the Hearing Aid meeting with Medicaid, they were going to treat each case for the developmentally delayed patients and children on a case by case basis in regards to getting two hearing aids for them and for getting hearing aids prior to 5 years. It doesn't appear that this has happened. Will this still be done?

North Dakota Medicaid Response:

The Department continues to reviews all hearing aid service authorization requests for members under 21 years old on a case by case base due to speech and educational development issues, as well as meeting the policy's hearing loss coverage criteria.

The Department considers **all** DME service authorization requests for equipment replacement based on if the equipment is still meeting the member's current medical needs and not the age or life expectancy of the equipment.

If the equipment is meeting the member's needs or can be repaired to meet their needs the request for replacement would be denied as not medical necessary.

Further Discussion:

- All children's HA requests are reviewed on case by case bases.
- Developmental disabled individuals are not eligible for 2 hearing aids after 21 years of age only eligible for one every 5 years. Would like to see this changed.

  The Department agreed that Tammy Zachmeier will review on a case by case bases denied SA requests of DD members if needed, but the member needs issues besides being DD to warranty coverage.

- Would the state consider using ENT that is already on staff? ENT is staffed though Quality Health Associates.

  North Dakota Medicaid is unable to partner with Quality Health Associates related to hearing aid reviews. Quality Health Associates does not have a ENT physician on staff at this time.

14. Why does the state not have a contracted audiologist looking at the service authorizations to make the determination?

    North Dakota Medicaid Response:

    The Department will continue to utilize the same contracted qualified medical physician to review North Dakota Medicaid's hearing aid requests due to budget restrictions.

15. I don't understand the appeal process. There is a statement in the policy that says "if the hearing decision is not in your favor, the total additional cost of those services will be considered an overpayment and you will be responsible to pay those costs". Can you review the appeal process?

    North Dakota Medicaid Response:

    The document being reference is part of the notification letter that is utilized for numerous service authorization types other than DME.

    DME Service Authorization requests can be denied for two basic reasons: Administrative reasons such as incomplete or missing forms and documentation, etc.; or the member does not meet the established criteria for coverage of the item.

    Following a denial for administrative reasons or a denial that is based on the member not meeting coverage criteria, a DME provider's "appeal" option is to submit a new service authorization along with additional information requesting that the decision be reconsidered. If the new service authorization request and additional information is received within thirty (30) days of the denial, with a clearly articulated request for reconsideration on the SFN 177 form, it will be handled as such.

    If a member was denied for not meeting established coverage criteria, the member has 30 days to request an appeal hearing.

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16. *North Dakota Medicaid must receive all service authorization requests within a timely manner.* ***Service authorization is to be submitted prior to the procedure taking place****. North Dakota Medicaid cannot process service authorizations once the service is more than one year old. Retro authorization will not be granted after a one year time frame has passed. Prior approval does not guarantee any form of payment.*

    North Dakota Medicaid Response:

    Please see the yellow highlight below that was added to the post for clarification for DME providers. Thank you for bring this to our attention.

ND Medicaid Provider Updates

Posted 9-22-2016

North Dakota Medicaid must receive all service authorization requests within a timely manner. **Service authorization is to be submitted prior to the procedure taking place**. North Dakota Medicaid cannot process service authorizations once the service is more than one year old. Retro authorization will not be granted after a one year time frame has passed. Prior approval does not guarantee any form of payment.

Be advised that DME timely filing will continue to require providers to submit all DME service authorizations within 90 days.

    Does this mean we no longer need to include a copy of the manufacturer's hearing aid repair invoice with the service authorization request as previously required?

    North Dakota Medicaid Response:

    Effective 1-1-1216 the hearing aid repairs (V5014) no longer required a service authorization request if the repair cost is $250 or less. If the same hearing aid requires more than 2 repairs regardless of the dollar amount a service authorization, will be required for approval.

    Further Discussions: Manufacturers invoice are required to be submitted for both SA requests and with claims requests.

17. Do they follow Medicare Osteogenesis Stimulators guidelines? What are their guidelines?

North Dakota Medicaid Response:

Please see North Dakota Medicaid's Osteogenesis Stimulator policy below. It is located on page 60 of the DME Provider Manual at

http://www.nd.gov/dhs/services/medicalserv/medicaid/provider-durable.html

OSTEOGENIC BONE STIMULATOR

CMN REQUIRED (SFN722)
Prior authorization required.

Coverage allowed if the following conditions are present for the following devices:

Non-Invasive Stimulator: (E0747, E0748)

- Nonunion of long bone fractures after six months from the fracture date and healing has ceased for 3 or more months prior to starting therapy with the osteogenic stimulator.
- Failed fusion when a minimum of 9 months has lapsed since last surgery.
- Congenital Pseudarthrosis, or
- Multi-level spinal fusion (3 or more vertebra).

Ultrasonic Stimulator: (E0760)

- Follow Medicare guidelines

Non-Covered If Diagnosis Of:

- Fresh fractures
- Fractures that are tumor related
- Fracture of the skull
- Requests must be from an orthopedic surgeon

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18. On page 7 of the DME Provider Manual it states the following:

    If a client is eligible for Medicaid, and the provider does not want to accept Medicaid payment for service or item requested, the client MUST be informed in advance of providing the service. The provider has a choice to provide or not provide service.

    1. Does this mean that we do not have to provide service?

       North Dakota Medicaid Response:

       See green highlighted section bullet three of the Provider Requirements. It states the provider has a choice to provide or not provide service. It is up to the provider.

    2. What does acceptance of client mean (is it for just that situation or for all)?

       North Dakota Medicaid Response:

       See the yellow section bullet six of the Provider Requirements. It states for services render for a Medicaid client that is billed to Medicaid. If a provider bills Medicaid for a service rendered for a Medicaid member then the provider accepted them.

PROVIDER REQUIREMENTS

By signing the application to enroll in North Dakota Medicaid, providers agree to abide by the conditions of participation addressed on the provider agreement. This form is available at http://www.nd.gov/eforms. This section includes:

- No client should be abandoned in a way that would violate professional ethics.
- Clients may not be refused service because of race, color, national origin, age, or disability.
- If a client is eligible for Medicaid, and the provider does not want to accept Medicaid payment for service or item requested, the client MUST be informed in advance of providing the service. The provider has a choice to provide or not provide service.

- When a provider arranges ancillary services for their Medicaid client through other providers the ancillary providers are considered to have accepted the client as a Medicaid client and they may not bill the client directly unless a service had been denied as non-covered.
- Most providers may begin Medicaid coverage for retroactively eligible clients at the current date or from the date retroactive eligibility was effective.
- When a provider bills Medicaid for services rendered to a client, the provider has accepted the client as a Medicaid client.

19. On Page 7 of the General ND Medical Assistance Manual it states the following:

    A. When a provider bills Medicaid for services rendered to a client, the provider has accepted the client as a Medicaid client.

    B. Once a client has been accepted as a Medicaid client, the provider may not accept Medicaid payment for some covered services but refuse to accept Medicaid payment for other covered services.

    Can you please clarify each of these statements? Which one applies and/or how do we know the difference?

    North Dakota Medicaid Response:

    The Department recommends DME providers utilize the DME Manual as it provides covered service information that applies specifically to services and supplies provided by Durable Medical Equipment, Orthotic, Prosthetic, and Medical Supply (DMEOPS) providers. Whereas, the General Information for Providers Manual addresses all health care services received by Medicaid members and services rendered by health care service providers.

    Further Discussion: Providers can't turn away former patients on Medicaid. They can turn away new Medicaid patient. Providers can limit the number of patients on Medicaid and Medicare that they will see.

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20. The DME Provider Manual states: Services must be ordered by a Physician (MD) operating within their scope of practice as defined by law. A few years ago your department began allowing Nurse Practioners and Physician Assistants to order services for their patients. According to the Provider Manual this is not allowed.

    Can you please explain which statement is correct and how we should proceed going forward?

    North Dakota Medicaid Response:

    Per North Dakota Administrative Code 75-02-02-08(1) (q)

    DME must be provided under the direction of a physician or other licensed practitioner of the healing arts within the scope of the physician's or practitioner's practice as defined by state law.

    North Dakota Medicaid for DME items will only accept physician (MD/DO/DPM), certified nurse practitioner (NP), physician assistant (PA),or a Clinical Nurse Specialist (CNS) signatures within the scope of their practice as defined by state law on service authorization requests

Additional Information:

- The Department has been receiving CMNs that have been modified by the providers, see example below.

  The purpose of the CMN is to be a quick reference guide to policy criteria (a user aid) not a replacement for required medical documentation or a required prescription. The CMN is not an all-inclusive guide for NDMA coverage criteria. Therefore is not a replacement for medical documentation.

  NDMA has been flexible in allowing physicians to utilize a CMN of their preference, which will at times require additional medical documentation to support medical necessity.

  NDMA is experiencing an increase in incomplete CMNs: sections not addressed, missing physician signature and/or not dated. This required information will result in the service authorization being denied, which delays the process.

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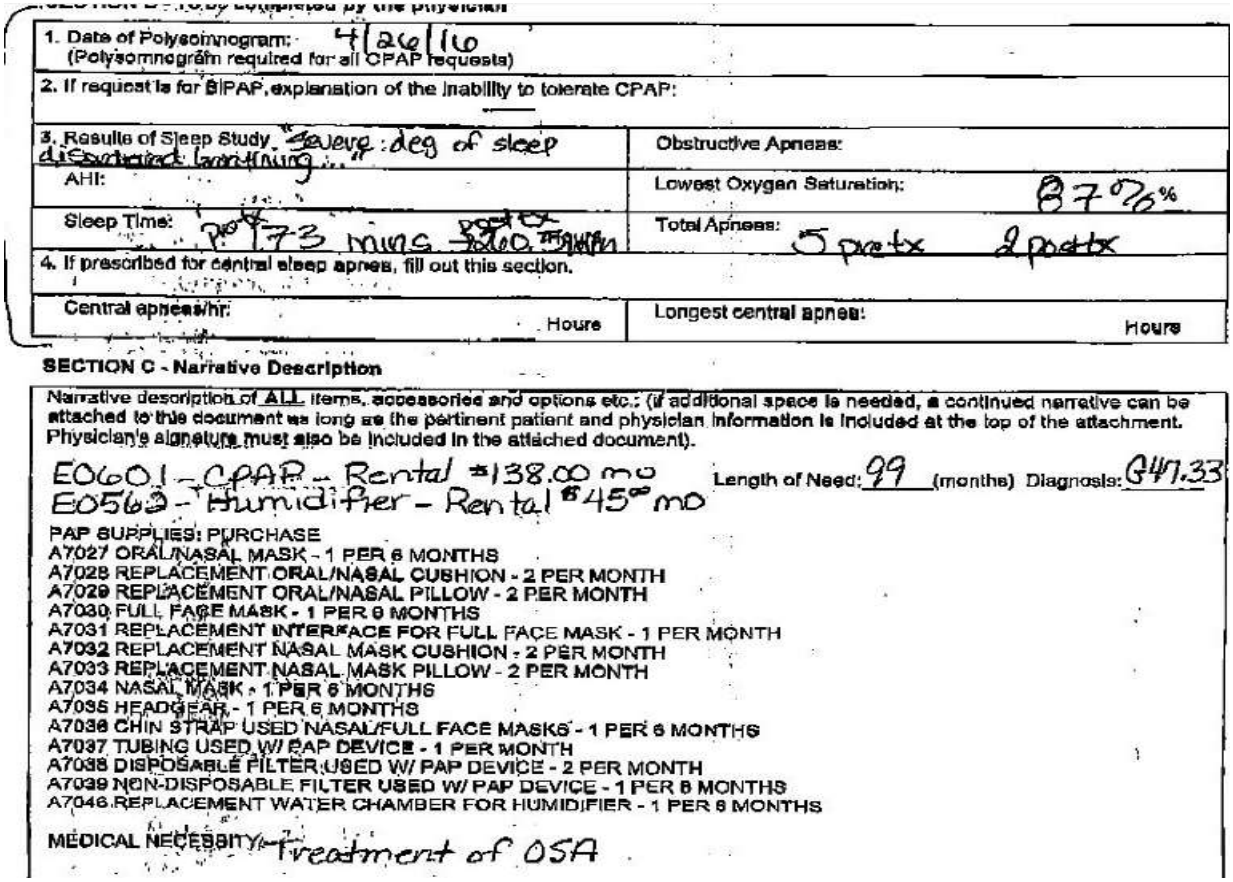
NDMA continues to utilize the same service authorization process per Department policy criteria for all new or re-certification prior authorization requests. By doing so, this shows NDMA is in compliance with Federal regulations during a Department's Surveillance/Utilization Review Section (SURS) or a Recovery Audit Contractor (RAC) audit.



1. Date of Polysomnogram: 4/26/16
(Polysomnogram required for all CPAP requests)

2. If request is for BIPAP, explanation of the inability to tolerate CPAP:

3. Results of Sleep Study: severe deg of sleep disordered breathing	Obstructive Apneas:
AHI:	Lowest Oxygen Saturation: 87%
Sleep Time: pre-173 mins post-tx 360 mins	Total Apneas: 5 pre-tx 2 post-tx

4. If prescribed for central sleep apnea, fill out this section.

Central apneas/hr: Houre	Longest central apnea: Hours

SECTION C - Narrative Description

Narrative description of ALL items, accessories and options etc.: (if additional space is needed, a continued narrative can be attached to this document as long as the pertinent patient and physician information is included at the top of the attachment. Physician's signature must also be included in the attached document).

E0601 - CPAP - Rental $138.00 mo
E0563 - Humidifier - Rental $45.00 mo
Length of Need: 99 (months) Diagnosis: G47.33

PAP SUPPLIES: PURCHASE
A7027 ORAL/NASAL MASK - 1 PER 6 MONTHS
A7028 REPLACEMENT ORAL/NASAL CUSHION - 2 PER MONTH
A7029 REPLACEMENT ORAL/NASAL PILLOW - 2 PER MONTH
A7030 FULL FACE MASK - 1 PER 6 MONTHS
A7031 REPLACEMENT INTERFACE FOR FULL FACE MASK - 1 PER MONTH
A7032 REPLACEMENT NASAL MASK CUSHION - 2 PER MONTH
A7033 REPLACEMENT NASAL MASK PILLOW - 2 PER MONTH
A7034 NASAL MASK - 1 PER 6 MONTHS
A7035 HEADGEAR - 1 PER 6 MONTHS
A7036 CHIN STRAP USED NASAL/FULL FACE MASKS - 1 PER 6 MONTHS
A7037 TUBING USED W/ PAP DEVICE - 1 PER MONTH
A7038 DISPOSABLE FILTER USED W/ PAP DEVICE - 2 PER MONTH
A7039 NON-DISPOSABLE FILTER USED W/ PAP DEVICE - 1 PER 6 MONTHS
A7046 REPLACEMENT WATER CHAMBER FOR HUMIDIFIER - 1 PER 6 MONTHS

MEDICAL NECESSITY: treatment of OSA

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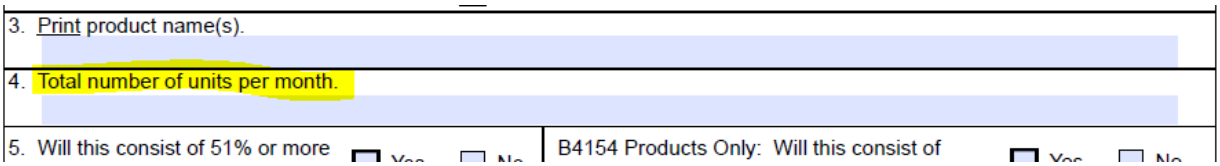
- CMN's for enteral products must have line 4 units listed to prevent a denial.



Units are per month. On the service auth. if the dates of service is for a year (12 months) the requested units need to be for 12 months to. For example; Dr. orders 450 units per month for a year. Take 12 months x 450 units per month = 5400 units. This is the total to be entered on ths service auth. request.

- PT, OT, Orthotist, Prosthetis notes are supporting documents, but are not a subsitiute for the required Dr. exam notes.

- What codes/reasons you will see when you check the status of your SA on the web portal.

  A1 – Certified in total –all items requested were approved as requested

  A2 – Certified – Partial – not items were approved

  A3 – Not Certified – SA denied

  A4 – Pended- waiting to be reviewed

  A6 – Modified – all items requested approved but not approved as requested. Example; labor units requested is 8 but only 6 was approved.

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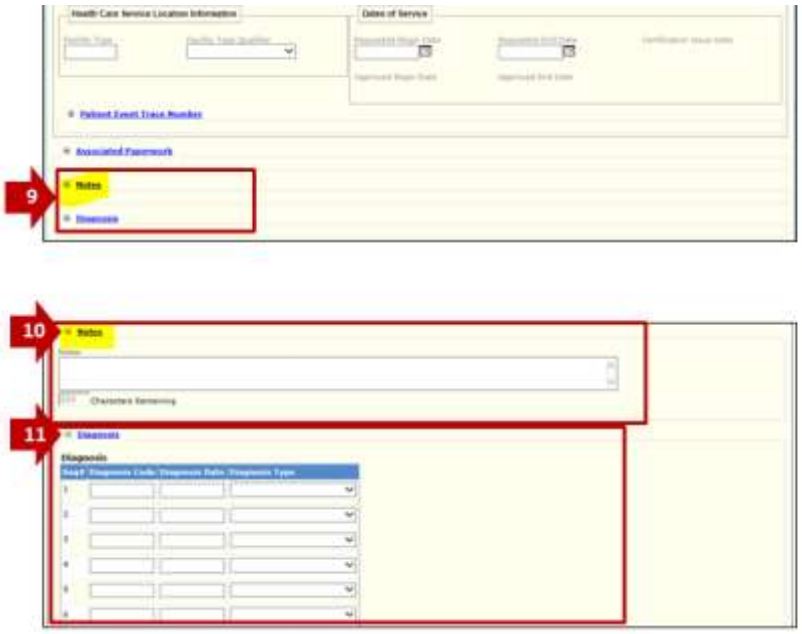
- Please remember to include on the SA notes section (see yellow highlighted section below) equipment date of purchase, equipment purchased prior to enter ti nursing home, insurance info., reason for early equipment replacment or any information the provider feels will assist during the review.



9. **Notes** and **Diagnosis** are expandable sections that you use to provide additional information to support your request.

Click **+** to open the **Notes** and **Diagnosis** sections.

10. Use **Notes** to provide any **required** information that you previously included on the paper SA form, including:

- Equipment date of purchase
- Equipment purchased prior to entering nursing home
- All insurances, if Medicaid is not the primary insurer
- Reasons for requesting early equipment replacement
- PLUS, any information that will help the reviewer processing the SA

After completing your notes, click **Save** at the bottom of the page/screen.

- The Department is happy to annouce that 70 HCPC codes are being reviewed to be removed from requiring service authorization. There will be perioidic post pay audits to appropriate billing and payment.

- The Department reminds providers to check Medicaid Provider's Update web page for important updates regarding policy changes, billing and coding guidance etc.

http://www.nd.gov/dhs/services/medicalserv/medicaid/provider-updates.html

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- If a SA needs a revision please see below when it is appropriate to request. Please email Tammy Holm at tamholm@ng.gov. Please include the SA number and information needing revision.

When To Request A SA Revision	When Not A SA Is Not Able to be Revised
Dates of service needs changing	Presviously denied for missing required supporting docs. like a RX, CMN, audiogram, sleep study, etc.,
Incorrect units.	Previously denied for missing information not recieved
Incorrect Requested Amount.	
Incorrect Asquistion Cost	
Incorrect MRSP	
Incorrect Monthly Rental Charge	

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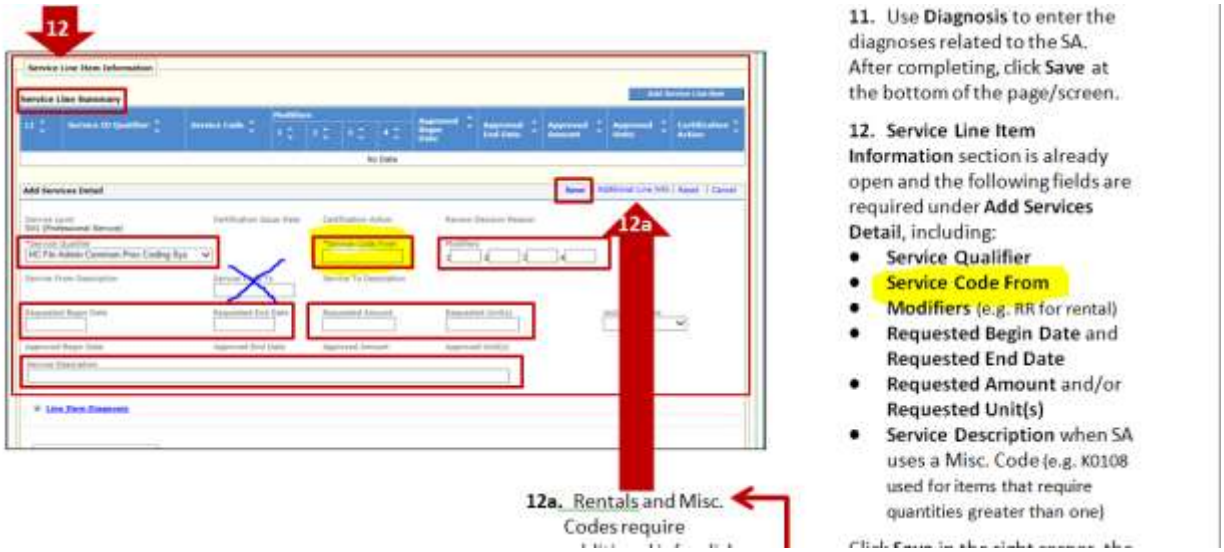
- When entering information on the Service Line Item only the Service Code from is required. Please do not utilize the Service Code to as it is not necessary for DME requests.



- **PROVIDER DOCUMENATION RESPONSIBILITY**

  - A DME supplier is responsible to maintain all North Dakota Medicaid member records, which include the following:

    1. Current, original physician orders, coverage decisions are not based solely on the prescription;

       The prescription must indicate:

       - Date the prescription was written
       - Patient name (first and last name)
       - Date of Birth **or** Medicaid ID Number
       - Name of the item prescribed
       - Quantity of the item/supply ordered
       - Directions for use
       - Physician signature and signature date
       - The length of need.

2. A complete CMN and additional medical necessity information provided by the physician/practitioner.
    - Failure to obtain a properly physician/practitioner signed, completed CMN is cause for denial/non-payment.
    - Periodically, a CMN may be added to this list and providers will be notified via the Departments website under the Update Provider Link: http://www.nd.gov/dhs/services/medicalserv/medicaid/provider.html

3. Detailed record of item(s) provided to include brand name, model number, quantity, and proof of delivery; and

4. Approved prior authorization/service authorization; and
    - Failure to obtain when required is cause for a denial/non-payment.

5. Documentation supporting the member or member's caregiver was provided with manufacturer instructions, warranty information, service manual, and operating instructions

    - Documentation must coincide with other documentation provided by those involved with the member.
    - The provider must obtain the required documentation in a timely manner as described under each section above.
    - Standard use of medical coding conventions is required when billing Medicaid. The most current edition of the following manuals should be used:

ICD-10-CM	ICD-10-CM diagnosis and procedure Codes definitions Updated each October	Available through various publishers and bookstores

HCPCS Level II	HCPCS Level II codes and definition Updated each January and through-out The year	Available through various publishers and bookstores or from CMS at www.cms.gov

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- When billing Medicaid, it is important to use the Department's DME fee schedule in conjunction with the detailed coding description listed in the current HCPCS Level II coding books. In addition to covered services, fee schedules often contain helpful information such as when a service authorization and CMN is required. Current fee schedules are available on the Provider Information website at http://www.nd.gov/dhs/services/medicalserv/medicaid/provider.html

  The online fee schedule is intended as a reference **not** a guarantee for payment.

- North Dakota Medicaid will only accept physician (MD/DO/DPM), certified nurse practitioner (NP), physician assistant (PA),or a Clinical Nurse Specialist (CNS) signatures within the scope of their practice as defined by state law on service authorization requests.

- The member must have been examined within the past 60 days and the physician must provide sufficient clinical rationale to substantiate the medical need of the ordered equipment or supplies.

- Member's history and current medical condition must be carefully considered before any prescription for equipment or supplies is written. The member's medical record must contain sufficient documentation, proof of delivery and original prescriptions and all must be made available upon request of the Department. The member's medical record is not limited to the physician's office records. It may include hospital, nursing home, or home-health agency records or records from other professionals.

- The provider's member medical records must contain sufficient documentation of the member's medical condition to substantiate the necessity for the type and quantity of items ordered and the frequency of the use or replacement. The information needs to include the member's diagnosis and other pertinent information, including but not limited to: duration of member's condition, clinical course (deteriorating or improving), prognosis, nature and extent of functional limitations, other therapeutic interventions and results, past experience with related items, etc. The records may include physician's office records, hospital, nursing home or home health records, records from other professionals including but not limited to: nursing, physical and occupational therapists, prosthetists and

orthotists, although medical necessity for item(s) requested must be stated by the prescribing physician/practitioner.

- The provider must maintain records in a readily accessible location and, for audit and investigation purposes, to make available upon request by Medicaid staff or its contractors, all supporting information related to prior/service authorizations, dispensed items, and/or paid clams for DMEPOS items.
- In the absence of proper and complete records, (as described thru out the above section labeled Provider Documentation Responsibility) *no payment will be made* and payments previously made will be recouped.
- All North Dakota Medicaid providers are required to follow the SFN 615 relative to documentation requirements. The agreement states the Provider agrees to document each item or service for which Medicaid reimbursement is claimed, at the time it is provided, in compliance with documentation requirements of the Department, applicable rules, and this agreement. Such records need to be maintained in hard copy for at least seven years after the dated of services or as required by rule. Upon reasonable request, the Department, the US Department of Health and the Human Services (DHHS) or their agencies, shall be given immediate access to, and permitted to review and copy all records relied on by the Provider in support of services billed to Medicaid. Copies will be furnished at the Provider's expense. The provider agrees to follow all applicable state and federal laws and regulations related to maintaining confidentiality of records.

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❖ SERVICE AUTHORIZATION (Prior Authorization)

Under the North Dakota Medicaid program, certain covered services and equipment require prior approval to provision of the service(s) as a condition of reimbursement. A service authorization submitted by the DME Provider and its attached required supporting documents is reviewed solely for medical necessity, appropriateness of items requested, location of service, if most cost-effective, and if in compliance with the Department's DME policy coverage criteria, prior to delivery of service.

Prior approval from the Department **only** pertains to medical necessity of the items requested on the service authorization. It does ***not*** guarantee payment, member eligibility or prevent later recoupment of claims paid, during an audit, if all billing and document/documentation requirements are not fulfilled.

❖ Medicaid DME Reimbursement

In December 2015, the President signed legislation (P.L. 114-113) that included a provision related to reimbursement for DME within the Medicaid program. Section 503 of Title V under Division O of the legislation limits Medicaid reimbursement to states for DME to Medicare payment rates. The provision would apply to services furnished on or after January 1, 2019.

On June 21, 2016 the Senate unanimously passed S. 2736, the "Patient Access to Durable Medical Equipment (DME) Act of 2016". The bill would delay a second scheduled Medicare cut to DME reimbursement rates in its non-DME bid areas for one year, lock future bid ceilings at the July 1 bid rates, and most relevant for the Medicaid program, move up the timeline for Medicaid DME reimbursement rates to match Medicare competitive bid rates from January 2019 to October 2018.

The House has approved a bill aimed at delaying the Medicare DME cuts. This version has an alternate timeline for delaying the cuts, and does not include the Medicaid DME piece. This bill also features previous legislation passed unanimously by the House - the Ensuring Access to Quality Medicaid Providers Act. That legislation would require states to create FFS provider directories, notify a federal database of providers terminated for cause, and require states to dis-enroll providers terminated for cause in another state. The White House previously issued a Statement of Administration Support for the package.

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The North Dakota Department of Human Services has accounted for the change in Medicaid DME reimbursement in the 2017-2019 Budget preparation.

While the Department would be required to implement any change (including decreases) to the North Dakota Medicaid DME Fee Schedule as a result of this federal legislation, the Department is interested in your feedback and in any recommendations you have as to how the agency can measure access for ND Medicaid recipients.

NDMA would like THANK ALL OF THE PROVIDERS for their patience, understanding, and cooperation this past year with the implementation of MMIS. The Providers are commended for their continued dedication and the service they provide for the NDMA beneficiaries.

Further Discussion: Doug Boknecht discussed with the group the North Dakota medicaid Access Monitoring plan. Surveys and questionaries were sent out to mediciad receipeints. Regarding access of care and services for our medicaid receipeints.

Introductions were made of all individuals that attended.

Again, NDMA would like THANK ALL OF THE PROVIDERS for their patience, understanding, and cooperation this past year with the implementation of MMIS. The Providers are commended for their continued dedication and the service they provide for the NDMA beneficiaries.